Nebraska Power of Attorney

Health Care

POWER OF ATTORNEY FOR HEALTH CARE

I, _____ (your name) name the following person as my attorney in fact for health care:

Name: _____

Address: _____

Phone Number:_____

SUCCESSOR TO POWER OF ATTORNEY FOR HEALTH CARE

If my agent (above) is unwilling or unable to act, I appoint the following person as my successor power of attorney for health care:

Name: _____

Address: _____

Phone number:_____

I understand the consequences of executing a power of attorney for health care and I authorize my attorney in fact for health care appointed by this document to make health care decisions for me when I am determined to be incapable of making my own health care decisions.

I direct that my attorney in fact for health care comply with the following instructions or limitations: _____

_____

I direct that my attorney in fact for health care comply with the following instructions on life-sustaining treatment: (*optional*) _____

_____

I direct that my attorney in fact for health care comply with the following instructions on artificially administered nutrition and hydration: (*optional*) _____

_____

I have read this power of attorney for health care. I understand that it allows another person to make life and death decisions for me if I am incapable of making such decisions. I also understand that I can revoke this power of attorney for health care at any time by notifying my attorney in fact for health care, my physician, or the facility in which I am a patient or resident. I also understand that I can require in this power of attorney for health care that the fact of my incapacity in the future be confirmed by a second physician.

_____ _____

Signature of person making designation *Date*

DECLARATION OF WITNESSES

We declare that the individual signing this power of attorney for health care is personally known to us, has signed or acknowledged his or her signature on this power of attorney for health care in our presence, and appears to be of sound mind and not under duress or undue influence. Furthermore, neither of us, nor the principal's attending physician, is the person appointed as attorney in fact for health care by this document.

Witnessed By:

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

_____ _____

(Signature of Witness/Date) (Printed Name of Witness)

OR

NOTARY

State of Nebraska

[County] of _____

This document was acknowledged before me on _____,

(Date)

by _____

(Name of Principal)

_____ (Seal, if any)

Signature of Notary

My commission expires: _____